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Focus. . .Family Planning and Unintended Pregnancy in Missouri

Subsidized family planning services are targeted at and mainly serve a population at high risk of unintended pregnancy. Unintended or unplanned pregnancy continues to be a problem in the United States and in Missouri. Nearly half of the pregnancies ending in a live birth or an induced termination in the United States each year are unintended (Henshaw, 1998). The consequences for the individual and for society have been well documented (Institute of Medicine, 1995). The rate of unintended pregnancy is higher among the young, the poor and minority women; women who are the most likely to utilize publicly funded sources for family planning. In this report family planning data reported by clinics funded through General Revenue (GR) Funds and many clinics funded by Title V[1] are analyzed. Data from other publicly funded programs that provide family planning such as Title X, Medicaid, and Federally qualified clinics[2] are not available. As with the report for previous years, data on minorities who reside in Missouri's major cities are incomplete and therefore minorities are under represented in this file.

For state fiscal year 1997 (July 1, 1996 - June 30, 1997) there were a total of 36,315 females who made initial (entry into the family planning) or annual (return) visits to family planning clinics funded by GR/Title V, an increase of 53.8 percent over fiscal year 1996. Not all these visits to GR/Title V funded clinics were paid for through General Revenue/Title V funds (13 percent from other funds) but are included because they represent a population in need of service. Nearly 60 percent of these visits were annual visits with the remaining being initial visits. Yet this is only a small proportion of those needing publicly supported contraceptive services according to estimates[3] by the Alan Guttmacher Institute (1998).

Certain groups of women are at greater risk of unintended pregnancy and form the bulk of the clientele for public family planning clinics. Women under the age of 20, over the age of 39, the never married, those with incomes below the poverty level and non-teenaged women with less than a high school education are at higher risk than are women 20-39, married women, those with incomes above the Federal Poverty Level and women with a high school education.

Women having one or more of the above noted risk factors accounted for 85 percent of all initial visits, nearly 76 percent of all annual visits and 80 percent of total visits. Although GR/Title V funded family planning clinics draw from a population at high risk of unintended pregnancy, as in previous years, clients making initial visits are even more at risk than are women making annual visits. As Table 1 indicates, nearly twice as many of the clientele making initial visits are under the age of twenty compared to those returning for an annual visit. Women making an initial visit are also more likely to have never been married than are women coming in for an annual visit. It appears that in FY 1997 even more of the initial clientele had incomes at or below 100 percent of the poverty level than in FY 1996.

After a family planning visit, ninety percent of the clients leave with one of the more effective prescription-based[4] means of contraception as is indicated in Table 2. Nine hundred seventy six or 2.7 percent of the clients leave the family planning visit without any method of contraception.

The choice of contraceptive method reflects the life stage of the client. Women 35 years of age or older rely more on over-the-counter[5] or permanent (sterilization) contraceptive methods. Women in the most fertile periods are more likely to rely on prescription-based methods. As with previous data, years of completed education do not relate to contraceptive choice but current student status is related with ninety-two percent of current students choosing a prescription-based method. Basically the same pattern prevails regardless of whether the client is entering the system or returning for an annual checkup.

The use of Depo-Provera is up across the board. Among all clients the choice of Depo Provera has increased nearly 50 percent (12.7 percent in FY 95 to 19.0 in FY 97). Non-teenaged women with less than a high school education are the ones most likely to choose Depo-Provera (25.7 percent) and show an increase of 94 percent since FY 95. Teenagers are the second highest (20.5 percent) in selecting Depo Provera as their contraceptive method. Older women (40 and older) are the least likely to use Depo-Provera but show the largest increase (from 6.9 in FY 95 to 16.4 percent in FY 1997).

Although Depo-Provera is less client-dependent than other prescription-based methods (other than Norplant), it does require the client to return on a regular basis for injection in order to maintain its effectiveness. Results from a national study suggest that one of the reasons low income women are at risk of unintended pregnancy is the high proportion who hold attitudes interfering with consistent contraceptive practice (Forrest & Frost, 1996)[6]. The National Survey of Family Growth (Peterson, et al. 1998) indicate that contraceptive failure is highest among the same groups that are at highest risk for unintended pregnancy (young women, poor women and members of minorities). Table 2 also shows that as was the case with previous years, females making an initial visit to the family planning clinics were less likely to choose oral contraceptives and more likely to choose Depo Provera than were women making an annual visit.

One of the primary purposes of family planning is the reduction in the number of unintended pregnancies. Although we cannot directly assess the reduction in the number of unintended pregnancies, we can look at intentionality of pregnancy and change in contraceptive practices.

During FY 1997 10.2 percent (3,706) of all clients making an initial or annual visit to a family planning clinic had been pregnant in the twelve months preceding the visit. Of these pregnancies, 35.6 percent were intended and 62.1 percent were unintended with the intention status of the remaining unknown (2.3 percent). As is indicated in Table 3 the rate of pregnancy was higher among clients making an initial visit to a family planning clinic than for women returning for an annual visit (163.5 versus 59.7 per 1,000 females). The rate for women returning for an annual visit was actually lower than the estimated state rate of 73.8. Nearly 65 percent of all clients who had a pregnancy in the last twelve months were making an initial visit to a family planning clinic.

Among those clients who had been pregnant within the last 12 months and who were making an initial visit to a family planning clinic the proportion of pregnancies which were intended was higher than in previous years yet over 60 percent of the pregnancies remain unintended. Again it must be noted that the clientele visiting public family planning clinics are at high risk for unintended pregnancy. Chart 1 compares the women with an unintended pregnancy with those who were not pregnant in the past twelve month. The women with unintended pregnancies are younger (80 percent under 25), poorer (55 percent under the poverty level) and with less education (40 percent with less than a high school education).

The aim of all family planning services is to help individuals control their fertility through avoiding or delaying pregnancy. Change in contraceptive behavior is a measure of the impact of family planning. As in previous years most clients are using contraception and usually a more effective method following a family planning visit than they were before the visit. Prior to their visit to the family planning clinic, over 3,300 clients who were neither pregnant nor seeking pregnancy were not using any method of contraceptive. Following the visit 76 percent of these clients were using a prescription-based contraceptive with an additional 11 percent using an over-the-counter method.

Both oral contraceptives and Depo Provera are highly effective when used consistently, however inconsistent use can be a problem among high risk groups. Peterson and associates (1998) report on inconsistency in oral contraceptive use related to specific characteristics. In their analysis 16 percent of all those using oral contraceptives were inconsistent with 35 percent of new users (3-6 months) reporting inconsistent use. In addition for users of oral contraceptive alone, having a previous unintended pregnancy was a significant predictor of inconsistent pill use. Peterson, et al (1998) suggest that for these clients who have difficulty with consistent contraceptive use, clinic care needs to be more individualized and perhaps more intensive.

Consequently, subsidized family planning clinics, which primarily serve a population at risk of unintended pregnancies, may need to not only provide contraceptives but also develop procedures to help their clientele use their chosen contraceptive in a consistent manner. The need for family planning services will not decrease in the foreseeable future and both individuals and society will benefit from reducing the incidence of unintended pregnancy.

[1]St. Louis County Clinics did not furnish individual client data for fiscal year 1997 and did not receive GR/Title V reimbursement but are participating in FY 1998.

[2]Community Health Centers, Migrant Health Centers, Certified Rural Health Clinics.

[3]Alan Guttmacher Institute estimates 338,630 women 13-44 are in need of publicly supported contraceptive services.

[4]Oral Contraceptives, cervical cap, IUD, Depo Provera, diaphragm and Norplant.

[5]Abstinence, natural family planning, withdrawal, condom, condom with spermicide, contraceptive foam, jelly or cream.

[6]Forest & Frost report that only 55 percent of the respondents in a telephone survey of low income women disagreed with the statement, "It doesn't matter whether I use birth control or not; when it is my time to get pregnant, it will happen".

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Table 1

Family Planning Female Clients Selected High Risk Characteristics by Type of Visit

Missouri General Revenue and Title V - Fiscal Year 1997

	Visit					
	Initial		*Annual*		*Total*	
High Risk Factors	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*
Age <20	6,426	43.5	5,040	23.4	11,466	31.5
Age 40 or older	290	2.0	679	3.1	969	2.7
Never Married	9,622	65.1	11,456	53.2	21,078	58.0
Below Poverty Level	6,393	43.2	7,908	36.7	14,301	39.3
Age GE 20 & <12 years Education	1,325	9.0	2,137	9.9	3,462	9.5
Any High Risk Factor	12,600	85.2	16,305	75.7	28,905	79.6
Total	14,783	100.0	21,532	100.0	36,315	100.0

Table 2

Family Planning Female Clients Birth Control Method by Visit Type
Missouri General Revenue and Title V - Fiscal Year 1997

	Visit				*Total*	
	Initial		*Annual*			
Number	Percent	Number	Percent	Number	Percent	

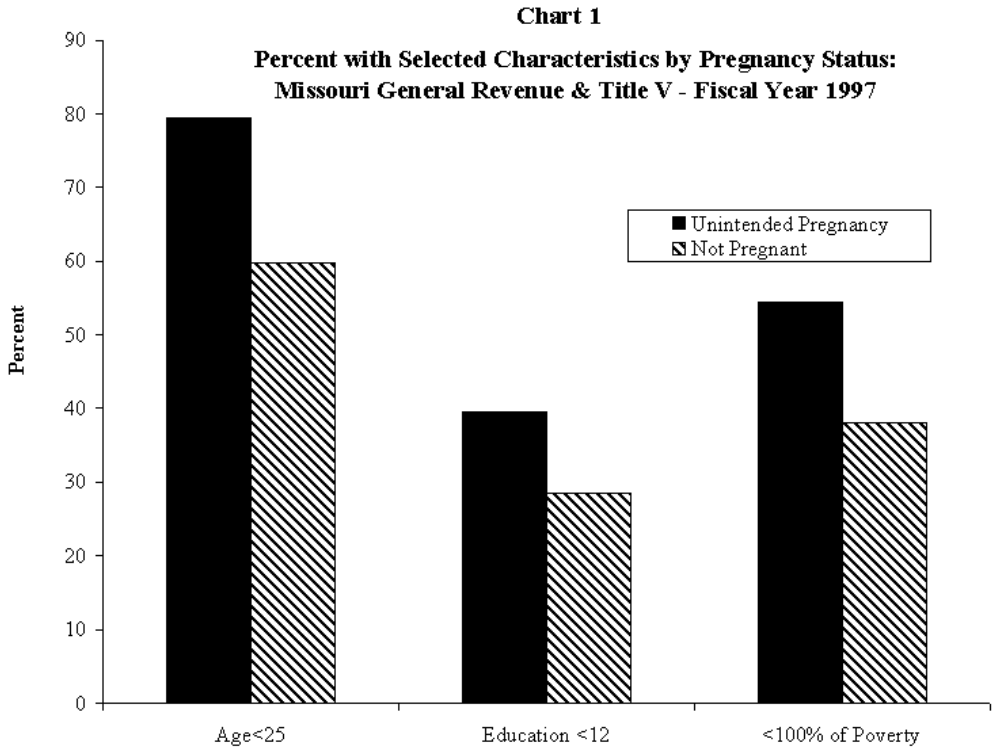
No Method	430	2.9	545	2.5	976	2.7
Abstinence	228	1.5	191	0.9	419	1.1
Natural Family Planning	32	0.2	32	0.1	64	0.2
Withdrawal	25	0.2	14	0.1	39	0.1
Contraceptive foam	25	0.2	28	0.1	53	0.1
Condom without spermicide	314	2.1	322	1.5	636	1.7
Condom and spermicide	683	4.6	745	3.5	1,428	3.9
Diaphragm	78	0.5	92	0.4	170	0.5
IUD	20	0.1	21	0.1	41	0.1
Cervical Cap	1	0.0	2	0.0	3	0.0
Depo Provera	3,126	21.1	3,778	17.6	6,904	19.0
Norplant	96	0.6	287	1.3	383	1.0
Birth Control Pill	9,672	65.4	15,347	71.3	25,019	68.9
Sterilization - Self/Partner	53	0.4	128	0.6	181	0.5
Total	14,783	100.0	21,532	100.0	36,315	100.0

Table 3

Pregnancy Rates

Clients Pregnant Within Past Year Missouri Family Planning Clients - Fiscal Year 1997

	Number	*Rate per 1,000 Females*
Initial Visit	2,420	163.7
Annual Visit	1,285	59.7
Overall State	87,628	73.8



Provisional Vital Statistics for February 1999

Live births increased in February as 6,208 Missouri babies were born compared with 5,836 in February 1998. The monthly birth rate increased from 14.0 to 14.8 per 1,000 population during this time period.

Cumulative births for the 12 months ending with February also shows an increase, from 73,542 in 1998 to 75,095 in 1999.

Deaths increased in February as 5,469 Missourians died compared with 4,993 one year earlier. However, cumulative deaths for the 2- and 12-month periods ending Febrary both show decreases.

The **Natural increase** in February was 739 (6,208 births minus 5,469 deaths). The rate of natural increase in February was 1.8 per 1,000 population.

Marriages decreased for all three time periods shown below. For the 12 months ending with February, marriages decreased by 3.3 percent from 44,604 to 43,131. **dissolutions of marriage** increased in February as 2,095 Missouri couples divorced compared with 2,003 in February 1998.

Infant deaths increased slightly in February as 53 Missouri infants died compared with 50 one year earlier. The infant death rate for the 12 months ending with February increased from 7.7 to 7.8 per 1,000 live births.

PROVISIONAL RESIDENT VITAL STATISTICS FOR THE STATE OF MISSOURI

Item	February				Jan.-Feb. cumulative				12 months ending with February				
	Number		Rate*		Number		Rate*		Number			Rate*	
	1997	1998	1997	1998	1997	1998	1997	1998	1997	1998	1996	1997	1998
Live Births	5,836	6,208	14.0	14.8	11,970	11,413	14.1	12.9	73,542	75,095	13.5	13.6	13.8
Deaths	4,993	5,469	12.0	13.0	10,245	9,771	12.1	11.0	54,616	52,905	10.1	10.1	9.7
Natural increase	843	739	2.0	1.8	1,725	1,642	2.0	1.9	18,926	22,190	3.4	3.5	4.1
Marriages	3,013	1,912	7.2	4.5	5,392	4,728	6.3	5.3	44,604	43,131	8.3	8.2	7.9
Dissolutions	2,003	2,095	4.8	5.0	4,184	4,033	4.9	4.5	26,074	25,648	4.7	4.8	4.7
Infant deaths	50	53	8.6	8.5	107	92	8.9	8.1	563	582	8.1	7.7	7.8
Population base (in thousands)	...	...	5,439	5,470	...	...	5,439	5,470	...	...	5,372	5,413	5,444

*Rates for live births, deaths, natural increase, marriages and dissolutions are computed on the number per 1000 estimated population. The infant death rate is based on the number of infant deaths per 1000 live births. Rates are adjusted to account for varying lengths of monthly reporting periods.

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